STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922279	11/14/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Eastbrooke Gardens	**201 Sunset Drive Casselberry, FL 32707**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D
St - A - E203 - 58a-5.030(4) Fac - Ecc - Staffing Requirements S-S= D
St - A - E210 - 58a-5.0191(7) Fac - Ecc - Training S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced biennial relicensure survey with Limited Nursing Services was conducted on

Eastbrook Gardens Adult Living Facility had deficiencies identified at the time of the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, record review and interview the facility failed to ensure physician orders were followed for 1 of 16 sampled residents (#4).

Findings:

Observation of the Medication Pass on at approximately 9:25 AM revealed the unlicensed staff was assisting resident #4 with self-administration of medications.

Review of the 2013 Medication Observation Record revealed the following medications were not given as ordered:

(for pain) 325 milligrams (mg) 2 tablets twice a day at 8:30 AM and 5 PM, was not charted as given on at 8:30 AM and 5 PM and 8:30 AM, the initials in the box were circled.
(for itching) 12% lotion apply to itchy area twice a day to back from neck to waist at 8:30 AM and 5 PM. Not charted as given, initials circled in the box on at 5 PM, at 8:30 AM and on at 8:30 AM.
(for lipids) 5 mg at bedtime at 8 PM, was not charted as given 8 PM on

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, 11/4 and initials were circled in the box.
(for 0.5 mg three times a day at 8:30 AM, 1 PM and 5 PM. Was not charted as given on at 5 PM, on and at 8:30 AM, 1 PM and 5 PM, and on at 8 AM, the initials in the box were circled.
One Daily/tab daily at 8:30 AM. Was not charted as given on at 8:30 AM.

Review of physician orders revealed orders dated:
325 mg 2 tablets twice a day.
12% lotion applies to itchy area twice a day to back from neck to waist.
5 mg at bedtime.
0.5 mg three times a day.
One Daily/tab

Review of the back of the 2013 MOR revealed:
One Daily/tab -waiting on family to deliver medication.
and 5 mg - waiting on family to deliver medication.
and 12% lotion - waiting on family to deliver medication.
and 0.5 mg - waiting on family to deliver medication.
and 325 mg - waiting on family to deliver medication.

Review of the Assisted Living Faculty Health Assessment Form (1823) dated stated diagnoses of and and stated the resident needed assistance with self-administration of medications.

Interview with Resident Care Director on at approximately 12:30 PM who stated the family provided the resident's medications and did not bring the above medications to the facility.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observations and interviews the facility failed to ensure that when staff provided assistance with self-administration of medications, the staff followed the appropriate procedure to take the medication, in its dispensed, properly labeled container to the resident, in the presence of the resident, read the label, open the container, remove a prescribed

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amount of medication from the container, close the container, and return the medication to storage for 4 of 16 sampled residents (#4, #5, #6, #7 & #8).

Findings:

Observation of the Medication Pass on . . . . . at approximately 9:25 AM revealed for residents #4, 5, 6, 7 & 8:

1. Resident #4 The Medication Tech, obtained medications from locked storage, compared the Medication Observation Record (MOR) to label, poured water, put medications in a cup, gave the cups with water and medications to the resident at the Medication Cart and stated here you go and stated the resident's name, watched the resident take the medications, returned medications to locked storage, put on gloves, put in eye drops, did not read the labels to the resident, returned the eye drops to locked storage and charted the medications.

2. Resident #5 The Medication Tech washed her hands, obtained meds from locked storage. She compared MOR to label, poured water, put medications in a cup, walked to the dining , gave the water and medications to resident, did not read the labels to the residents, watched the resident take the medications, returned medications to locked storage, charted meds and washed hands.

3. Resident #6 The Medication Tech washed her hands, obtained meds from locked storage, took pills in cup and water to resident's , stated I have your medicine, gave resident water, watched resident take meds, gave the resident his inhaler, returned meds to locked storage, charted meds and washed hands.

4. Resident #7 The Medication Tech, obtained medications from locked storage, compared the Medication Observation Record (MOR) to label, poured water, put medications in a cup, gave the cups with water and medications to the resident at the Medication Cart, watched the resident take the medications, returned medications to locked storage, charted meds and washed hands.

5. Resident #8 The Medication Tech was observed at approximately 9:40 AM crushing medications for the resident and putting them in applesauce. She took the cup with medications to the resident, who was sitting at the dining , fed the applesauce with medications in it to the resident with a spoon ,did not read the label, returned to the medication cart, charted the medications and washed her hands.

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The unlicensed staff did not follow the appropriate procedure to take the medication, in its dispensed, properly labeled container to the resident, in the presence of the resident, read the label, open the container, remove a prescribed amount of medication from the container, close the container and return the medication to storage.

In an interview with the Resident Care Director on at approximately 3:30 PM who was not aware the unlicensed staff was not following the proper procedure when assisting with self-administration of medications.

Class III

0053-Medication - Administration 58A-5.0185(4) FAC
Based on observation, record review and interview the facility failed to ensure medications were administered by a licensed staff for 1 of 16 sampled residents (#5).

Findings:

Observation on at approximately 9:25 AM for resident #5 revealed the Medication Tech washed her hands, obtained meds from locked storage, compared the Medication Observation Record to label, poured water, put medications in a cup, walked to the dining , gave the water and medications to resident, did not read the labels to the residents, watched the resident take the medications, returned medications to locked storage, charted meds and washed hands.

Review of the Assisted Living Facility Health Assessment Form (1823) dated stated diagnosis of and stated the resident needed medication administered.

The unlicensed staff administered medications to resident #5 and a nurse was required to administer medications to the resident per the physician's order.

In an interview with the Resident Care Director on at approximately 3:30 PM who stated she was not aware the resident needed medications administered.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on record review and interview the facility failed to make every reasonable effort to

ensure medications for1 of 16 sampled residents (#4), who received assistance with self-administration of medications, was refilled in a timely manner.

Findings:

Observation of the Medication Pass on at approximately 9:25 AM revealed the unlicensed staff was assisting resident #4 with self-administration of medications.

Review of the 2013 Medication Observation Record revealed the following medications were not given as ordered:

(for pain) 325 milligrams (mg) 2 tablets twice a day at 8:30 AM and 5 PM, was not charted as given on at 8:30 AM and 5 PM and 8:30 AM, the initials in the box were circled.
(for itching) 12% lotion apply to itchy area twice a day to back from neck to waist at 8:30 AM and 5 PM. Not charted as given, initials circled in the box on at 5 PM, at 8:30 AM and on at 8:30 AM.
(for lipids) 5 mg at bedtime at 8 PM, was not charted as given 8 PM on , 11/4 and initials were circled in the box.
(for 0.5 mg three times a day at 8:30 AM, 1 PM and 5 PM. Was not charted as given on at 5 PM, on and at 8:30 AM, 1 PM and 5 PM, and on at 8 AM, the initials in the box were circled.
One Daily/tab daily at 8:30 AM. Was not charted as given on at 8:30 AM.

Review of physician orders revealed orders dated:
325 mg 2 tablets twice a day.
12% lotion apply to itchy area twice a day to back from neck to waist.
5 mg at bedtime .
0.5 mg three times a day.
One Daily/tab

Review of the back of the 2013 MOR revealed:
One Daily/tab - waiting on family to deliver medication.
and 5 mg - waiting on family to deliver medication.
and 12% lotion - waiting on family to deliver medication.
and 0.5 mg - waiting on family to deliver medication.

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and 325 mg - waiting on family to deliver medication.

Review of the Assisted Living facility Health Assessment Form (1823) dated stated diagnoses of and and stated the resident needed assistance with self-administration of medications.

Interview with Resident Care Director on at approximately 12:30 PM who stated the family provided the resident's medications, and did not bring the above medications to the facility.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on interview and personnel record review the facility failed to ensure that freedom from obtained from a healthcare provider, not a Licensed Practical Nurse (LPN) and within 30 days of hire; for 1 of 5 sampled staff (D).

Findings:

Personnel record review at approximately 3 PM revealed staff D was hired
Continued review revealed a test done and read by a facility Licensed Practical Nurse on A statement free of communicable was dated and was signed by an Advanced Registered Nurse Practitioner (ARNP). His license number and address were not indicated on the statement.

The Resident Care Director (staff D) stated on at approximately 4 PM she did not know a nurse could not interpret test results and the doctor's statement was done late.

Class III

0162-Records - Resident 58A-5.024(3) FAC
Based on observation, record review and interview the facility failed to ensure health care provider's orders were obtained for the facility to assist 2 of 16 sampled residents (#7 & #8) with self-administration of medications.

Findings:

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Observation of the Medication Pass on [redacted] at approximately 9:25 AM revealed the unlicensed staff assisted residents #7 and #8 with self-administration of medications.

Review of the Assisted Living Facility Health Assessment Forms (1823) revealed:
Resident # 7 had an 1823 with a diagnosis of [redacted] dated [redacted] that did not state what type of assistance was needed with medications.

Resident # 8 had an 1823 dated [redacted] with a diagnosis of [redacted] that did not state what type of assistance was needed with medications.

Interview with the Resident Care Director on [redacted] at approximately 3:30 PM who was not aware the 1823's for residents #7 and #8 did not state what type of assistance they needed with medications.

Class III

E203-ECC - Staffing Requirements 58A-5.030(4) FAC
Based on interviews and personnel record review the facility failed to provide, as staff or by contract, the services of a nurse who must be available to provide nursing services as needed by Extended Congregate Care residents, participate in the development of resident service plans and perform monthly nursing assessments

Findings:

The administrator stated on [redacted] at approximately 3:15 PM that the facility had a contract with Central Florida Home Health to provide a Registered Nurse (RN), staff E, to provide ECC services. The administrator was given the opportunity to locate the contract. She stated on [redacted] at approximately 5 PM that was unable to locate any additional documentation.

The Registered Nurse (staff E) stated on [redacted] at approximately 4:30 PM in a telephone interview that she attended ALF Core and ECC training but was in the process of moving and was unable to locate her ECC training certificate. She stated there had been no resident that needed ECC. Then stated there were 2 residents that had [redacted] and needed nursing. She added that she had other nurses who also went to the facility to see those residents as well. I asked what she meant, other nurses. She the stated that she was in contract with the facility thru Central Florida Home Health to provide ECC if needed. The 2 residents were

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under the care of Central Florida Home Health, not the facility, not ECC and home care agency staff provided care to the residents.

A telephone interview was conducted on [redacted] at approximately 9:20 AM with staff E to clarify her date of hire. I asked her again when did she became the facility ECC nurse. She stated that she was not aware that a contract had been signed between the facility and the home care agency. She was never told about it. When she was first hired by the home care agency a selling point was that she was ECC trained therefore had an understanding of the concept of aging in place. She was never told that she was Eastbrooke's Extended Congregate Care nurse.

Class III

E210-ECC - Training 58A-5.0191(7) FAC
Based on interviews and personnel records review the facility failed to ensure that 2 of 5 direct care staff (D & E) who provided care to residents in an extended congregate care (ECC) program completed at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months of beginning employment in the facility.

Findings:

The Licensed Practical Nurse/Resident Care Director (staff D) stated on [redacted] at approximately 2:25 PM she was hired [redacted] 2013. She had not been to ECC training. The facility did not generally admit residents who required higher level of care. Her understanding of the ECC process was if a resident needed ECC, the RN would do an assessment. She would come every month check records, monitor records, complete service plans and check on the resident. It was her understanding that the facility did not provide any nursing services.

Personnel record review at approximately 3 PM revealed staff D was hired [redacted] and there was no evidence to confirm she received the mandated ECC in-service training.

The RN (staff E) stated on [redacted] at approximately 4:30 PM in a telephone interview that she attended ALF Core and ECC training but was in the process of moving and was unable to locate her ECC certificate of training.

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Personnel record review at approximately 3 PM for staff E revealed no evidence to confirm she received the mandated ECC in-service training.

The administrator stated on , at approximately 5 PM that staff D had not been to ECC training and she had no evidence to confirm the RN attended the training or a contact.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Eastbrooke Gardens
201 Sunset Drive
Casselberry, FL 32707

Dear Administrator:

Re: Biennial w/ECC

This letter reports the findings of a state licensure survey that was conducted on , 2013 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after , **2013,** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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